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ABSTRACT

The purpose of the Physician Consortium on Substance Abuse Education is to promote the role of physicians in prevention, diagnosis, treatment, and after-care referral for substance abuse by improving medical education and training. This policy report is the product of 2 years of work and a national conference of the consortium and presents in full its findings on medical education in substance abuse at the interface of the health and criminal justice systems. The report makes recommendations for improving the quality of medical education and the ability of physicians to work more effectively with professionals in the criminal justice system, including police, courts, and local, state, and federal detention systems. The report is intended for widespread circulation to national medical organizations and to federal and state agencies for their use in supporting the education of physicians to overcome the barriers to effective treatment of substance abuse. Following listings of represented organizations and conference participants and an executive summary, the report's contents are: (1) "Physician Consortium on Substance Abuse Education"; (2) "Consortium Deliberations"; (3) "Findings of the Physician Consortium"; (4) "Recommendations of the Physician Consortium"; (5) "Background on the Substance Abuse Problem"; (6) "Pre-Trial Services"; and (7) "Background on Drug Courts." (Contains 20 references.) (EV)

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SECOND POLICY REPORT

OF THE PHYSICIAN CONSORTIUM ON SUBSTANCE ABUSE EDUCATION

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Substance Abuse and Addiction: The Interface of the Health and Criminal Justice Systems

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SECOND POLICY REPORT

Of The Physician Consortium On Substance Abuse Education

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Substance Abuse and Addiction: The Interface of the Health and Criminal Justice Systems

David C. Lewis, M.D., Chairperson
Walter L. Faggett, M.D., Vice Chairperson

Supported by the
HEALTH RESOURCES AND SERVICES ADMINISTRATION
Bureau of Health Professions
Division of Medicine

Staffed by the
Primary Care Medical Education Branch

The views expressed in this document are solely those of the Physician Consortium on Substance Abuse Education and do not necessarily represent the views of the Health Resources and Services Administration or the United States Government.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Health Resources and Services Administration
Rockville MD 20857

Donna E. Shalala
Secretary, Department of Health and Human Services

Dear Madame Secretary:

I am pleased to submit to you the Second Policy Report of the Physician Consortium on Substance Abuse Education, Substance Abuse and Addiction: The Interface of the Health and Criminal Justice Systems. The purpose of the Physician Consortium is to promote the role of physicians in prevention, diagnosis, treatment, and after-care referral for substance abuse by improving medical education and training. This second major Consortium product advances the work of the Consortium's agenda. The first policy report, in concert with efforts of other national organizations, persuaded the Nation's medical schools and graduate training programs to adopt new requirements in the education and training of physicians to strengthen their abilities to care for persons with substance abuse problems.

During the period between the first Policy Report and the present, the Consortium has examined the role and responsibilities of the medical profession in caring for persons who have become involved in the criminal justice system because of use of illegal substances.

The most recent national conference of the Physician Consortium was an historic event. Professionals from both the medical and criminal justice communities met to discuss issues of joint concern. That meeting led to a series of recommendations for joint actions that we believe will produce greater understanding among physicians and criminal justice professionals on improved approaches to caring for persons with substance abuse problems. This report hopefully will parallel the success of the first Policy Report and lead to significantly greater understanding and knowledge among the Nation's physicians.

Staff of the Health Resources and Services Administration's (HRSA) Bureau of Health Professions Division of Medicine worked with the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment and the Center of Substance Abuse Prevention and the Department of Justice to make the most recent national conference a success.

As HRSA Administrator, I look forward to working again with my colleagues in SAMHSA and the Department of Justice to continue to move forward on this vital subject. There are few more important issues in the country today than substance abuse, and all its attendant ills. We plan to continue working to improve physician education in substance abuse.

Sincerely,

Claude Earl Fox, M.D., M.P.H.
Administrator

ACKNOWLEDGEMENT

The *Physician Consortium on Substance Abuse Education* gratefully acknowledges David C. Lewis, M.D., Chair, for his visionary leadership in working with his Consortium colleagues, JudyAnn Bigby, M.D., Michele Cyr, M.D., Walter Faggett, M.D., Sheldon I. Miller, M.D., Eugene Oliveri, D.O., and S. Kenneth Schonberg, M.D., and for bringing together the medical substance abuse education leadership and leaders in the criminal justice system. The initial efforts begun by the Physician Consortium leadership were assisted by Sarah Vogelsburg, Drug Policy Advisor, Office of the Secretary, who considered it essential that the Consortium examine issues in its purview in relation to the Crime and Substance Abuse Initiative put forward by the Secretary of Health and Human Services and the Attorney General.

The Physician Consortium also acknowledges gratefully the early contributions by members of the Justice Department through their insightful presentations and provision of relevant resource materials. In particular, Kenneth P. Moritsugu, M.D., Assistant Surgeon General, Medical Director, Federal Bureau of Prisons, and members of his staff, Ron Allen, H. Curt Toler, and Beth Weinman contributed substantially to this effort. Later, for the success of this national conference and the opportunity to work together, the Physician Consortium is indebted to others within the Justice Department without whom this report would not have been possible: the plenary speakers, D. Alan Henry, Director of Pre-Trial Services Resources Center, and his colleague, Timothy Murray, Director of Policy, Bureau of Justice Assistance. The Physician Consortium wishes to recognize the assistance of Jenifer Brophy, Drug Courts Program Office, for materials provided Consortium members.

The Physician Consortium is also indebted to the collaborative efforts of staff of HRSA's sister agency, the Substance Abuse and Mental Health Services Administration. Particular thanks are due Nick Demos, Chief, Criminal Justice Branch, and Susan Rohrer, Office for Scientific Analysis and Evaluation, and their leaders. All the members of the Physician Consortium are thanked for making available their expertise and guidance during the meeting deliberations and their informative perspectives and insights in the writing of this report.

The preparation of this *Second Policy Report of the Physician Consortium on Substance Abuse Education* was assisted greatly by staff of the Health Resources and Services Administration located in the Bureau of Health Professions, Office of the Director. Enrique S. Fernandez, M.D., M.S.Ed., Director, Division of Medicine, serves as the Executive Secretary of the Physician Consortium. Ruth Kahn, D.N.Sc., Health Professions Education Specialist, Office of the Director, performed the final editorial work on this report. Significant assistance with the planning and implementation of the Physician Consortium meetings that led to the writing of this report was provided by Ellie Grant, Anne Patterson, and Shirley Linney, staff of the Primary Care Medical Education Branch, Division of Medicine. Appreciation for technical assistance with the Physician Consortium meetings is also due Lisa Flach, Office of the Director, Division of Medicine, and Waldo Mojica, Office of Program Support, Bureau of Health Professions. Special thanks are due the Chief, Carol Bazell, M.D., M.P.H., Primary Care Medical Education Branch, for her assistance and direction through all phases of the work and final review of the written report. John Heyob, Deputy Director, Division of Medicine, is also thanked for his expert administrative support.

For further information regarding this *Second Policy Report of the Physician Consortium on Substance Abuse Education*, please contact:

Ruth H. Kahn, D.N.Sc.
Health Professions Education Specialist
Office of the Director,
Division of Medicine
Bureau of Health Professions
Health Resources and Services Administration
5600 Fishers Lane, Room 9A-27
Rockville, Maryland 20857
Tel: 301/443-6823 or 6190
Fax: 301/443-8890

PREFACE

Mainstream medical education has been changing over the past five years to integrate substance abuse increasingly into the curriculum. Virtually every national professional medical society now has a task force or working group on substance abuse education. Some examples of organizations making progress in this area include:

- The Association for Medical Education and Research in Substance Abuse (AMERSA), the national medical faculty organization for physicians and other health professionals devoted to substance abuse education, has played an important role in sustaining faculty development and explicating the way in which skills training can be a central part of the curriculum.
- The American Society of Addiction Medicine (ASAM) has advanced the education of specialists and primary care physicians.
- The American Academy of Addiction Psychiatry (AAAP) provides leadership in addiction psychiatry and has now integrated substance abuse education into the training of psychiatrists.

Federal initiatives have also stimulated change through new and continuing programs:

- The Health Resources and Services Administration (HRSA) has added to the momentum by supporting advancement of new medical school curricula, faculty development and training opportunities for primary care physicians.
- The Substance Abuse and Mental Health Services Administration (SAMHSA) has implemented the Addictions Technology Transfer Centers to improve the dissemination and application of research-based knowledge to health professionals for substance abuse and mental health prevention and treatment.
- Increasingly, the National Institutes of Health (NIH) have contributed substantially to medical education—first and foremost through advances in medical science, but also by developing guides for primary care physicians.

The Physician Consortium on Substance Abuse Education has concentrated on advancing the basics—requirements that every medical student, resident and practicing physician possess the knowledge and skills to prevent, screen, diagnose, treat, follow and refer patients with alcohol, tobacco, and other drug problems. Furthermore, we have examined the role of the medical profession in providing care to individuals who are incarcerated in the Nation's jails and prisons and who suffer from drug or alcohol problems. In our early discussions of prison care we realized that we had identified a major national problem—issues of the interface between the medical and criminal justice systems. By encouraging dialogue between professionals in both communities, we created the momentum to plan and convene a national conference. We were aided in carrying out this plan by the able assistance of staff from the U.S. Departments of Health and Human Services and Justice.

The conference was an historic event. It marked the first time that representatives from so many national professional organizations in health and criminal justice assembled together and reached a consensus on the need for joint training. We hope this report of the conference contributes to the ongoing dialogue and to the quest for solutions to this continued national crisis.

David C. Lewis, M.D.
Chairperson

PHYSICIAN CONSORTIUM ON SUBSTANCE ABUSE EDUCATION

CHAIRPERSON

David C. Lewis, M.D.
Association for Medical Education and Research
Brown University
Center for Alcohol and Addictions Studies - Box G
Providence, RI 02912
Tel (401) 444-1818 Fax (401) 444-1850

VICE CHAIRPERSON

Walter L. Faggett, M.D.
National medical Association
TENNCARE
Memphis, TN
Tel (901) 348-3334 Fax (901) 346-0790

EXECUTIVE SECRETARY

Enrique S. Fernandez, M.D., M.S.Ed.
Director, Division of Medicine
Bureau of Health Professions
Health Resources and Services Administration
Parklawn Building Room 9A-27
5600 Fishers Lane
Rockville, MD 20857
Tel (301) 443-6190 Fax (301) 443-8890

ORGANIZATIONS REPRESENTED

Accreditation Council for Graduate Medical Education (ACGME)
515 North State Street
Chicago, Illinois 60610
(312) 464-5000
John Gienapp, Ph.D.
James P. Weinlander, Ph.D.

Ambulatory Pediatric Association (APA)
6728 Old McLean Village Drive
McLean, Virginia 22101
(703) 556-9222
William Bithoney, M.D.
Steven Greer, M.D.

American Academy of Child and Adolescent Psychiatry (AACAP)
3615 Wisconsin Avenue, N.W.
Washington, D.C. 20016
(202) 966-7300
Anne Rowan, M.D.

American Academy of Family Physicians (AAFP)
8880 Ward Parkway
Kansas City, Missouri 64114
(816) 333-9700
Neil H. Brooks, M.D.
Melvan Gerald, M.D., M.P.H.

American Academy of Pediatrics (AAP)
P.O. Box 927
Elk Grove Village, Illinois 60009
(312) 228-5005
S. Kenneth Schonberg, M.D.

American Academy of Psychiatrists in Alcoholism and Addiction (AAPAA)
P.O. Box 376
Greenbelt, Maryland 20770
(301) 220-0951
Sheldon I. Miller, M.D.

American Association of Colleges of Osteopathic Medicine (AACOM)
5550 Friendship Blvd
Suite 300
Chevy Chase, Maryland
(301) 968-4100
Douglas O. Wood, D.O., Ph.D.

Association of Community Psychiatrists
Center for Addiction Studies
St. Francis Medical Center
University of Pittsburgh
400 45th Street
Pittsburgh, Pennsylvania 15201
Wesley Sowers, M.D.

American Board of Family Practice (ABFP)
2228 Young Drive
Lexington, Kentucky 40505
(606) 269-5626
Robert Avant, M.D.
Macaran A. Baird, M.D.

American Board of Medical Specialties (ABMS)
One Rotary Center, Suite 805
Evanston, Illinois 60201
(708) 491-9091
Barbara S. Schneidman, M.D., Ph.D.

American Board of Pediatrics (ABP)
111 Silver Cedar Court
Chapel Hill, North Carolina 27514
(919) 929-0461
Catherine DeAngelis, M.D.

American College of Emergency Physicians (ACEP)
P.O. Box 619911
Dallas, Texas 75261
(214) 550-0991
Larry Bedard, M.D.
Frederick J. Allen, M.D.

American College of Obstetrics and Gynecology (ACOG)
409 12 th Street, S.W.
Washington, D.C. 20024
(202) 638-5577
Marvin Hage, M.D.

American College of Physicians (ACP)
Independence Mall West
6th Street at Race
Philadelphia, Pennsylvania 19106-1572
(215) 351-2400
Michele Cyr, M.D.

American College of Preventive Medicine
PO Box 1000
Binghanpton, New York 13902
(607) 770-8521
Arnold J. Schecter, M.D., M.P.H.

American Medical Association (AMA)
515 North State Street
Chicago, Illinois 60610
(312) 464-5000
John J. Ambre, M.D., Ph. D
Richard Yoast, Ph.D.

American Medical Student Association (AMSA)
1890 Preston White Drive
Reston, Virginia 22091
(703) 620-6600
Joan Hedgecock, Assistant Director
Andrew J. Norwalk, Past President
Kavita Patel, President

American Osteopathic Association (AOA)
142 East Ontario Street
Chicago, Illinois 606112864
(312) 280-5800
Eugene Oliveri, D.O.
Joseph P. McNerney, D.O.

American Psychiatric Association (APA)
1400 K Street, N.W.
Washington, D.C. 20005
(202) 682-6000
Sheldon I. Miller, M.D.
Roger Meyer, M.D.

American Society of Addiction Medicine (ASAM)
5225 Wisconsin Avenue, N.W., Suite 409
Washington, D.C. 20016
(202) 244-8948
James Callahan, D.P.A.
Blair Carlson, M.D.

Association for Medical Education and Research in Substance Abuse (AMERSA)
Brown University, Box G
Providence, Rhode Island 02912
(401) 863-3173
David C. Lewis, M.D.
Richard Blondell, M.D.

Association of American Medical Colleges (AAMC)
1 DuPont Circle, N.W., Suite 200
Washington, D.C. 20036
(202) 828-0579
Lois Bergeisen

Association of American Indian Physicians (AAIP)
10015 South Pennsylvania, Building D
Oklahoma City, Oklahoma 73159
(405) 692-1202
Phillip Smith, M.D.

Association of Teachers of Preventive Medicine
1660 L Street N.W., Suite 208
Washington, D.C. 20036-5603
(202) 463-0550
Gregory L.Phelps, M.D.
Robert Pinter, M.D.

Charles R. Drew University of Medicine and Science
1621 East 120th Street
Los Angeles, California 90059
(213) 563-4974
Lewis M. King, M.D.

InterAmerican College of Physicians and Surgeons (ICPS)
299 Madison Avenue
New York, New York 10017
(212) 599-2737
Rene F. Rodriguez, M.D.
Cesar Fabiani, M.D.

Medical College of Virginia Hospital
Virginia Commonwealth University
Box 109, MCV Station
Richmond, Virginia 23298-0001
(804) 786-9914
Sidney H. Schnoll, M.D., Ph.D.

Meharry Medical College
1005 David B. Todd Boulevard, Box A7
Nashville, Tennessee 37208
(615) 327-6774
Howard Burley, M.D.
Zia Wahid, M.D.

Morehouse School of Medicine and Cork Institute
720 Westview Drive, S.W.
Atlanta, Georgia 30310
(404) 752-1780
John O. Gaston, M.D.
Donnie Watson, Ph.D.

National Association of Minority Medical Educators (NAMME)
University of Medicine and Dentistry of New Jersey
Medical Science Building, C-658
185 South Orange Avenue
Newark, New Jersey 07103
(210) 982-5431
James A. Foster, M.P.A.
Charles Alexander, Ph.D.

National Board of Medical Examiners (NBME)
3930 Chestnut Street
Philadelphia, Pennsylvania 19104
(215) 349-6400
L.Thompson Bowles,M.D., Ph.D.

National Medical Association (NMA)
1012 10th Street, N.W.
Washington, D.C. 20001
(202) 347-1895
Walter L. Faggett, M.D.

Society of Adolescent Medicine (SAM)
10727 White Oak Avenue, Suite 101
Granada Hills, California 91344
(818) 368-5996
S. Kenneth Schonberg, M.D.

Society for Academic Emergency Medicine
901 North Washinton Ave.
Lansing, Michigan 48906
(517) 485-5484
Edward Bernstein, M.D.

Society of Correctional Physicians
110 Spoonbill Road
Manlapan, Florida 33462-4755
(561) 547-0501
Peter Lamelas, M.D., M.B.A., President
Richard Gottula, M.D., President-Elect

Society of General Internal Medicine (SGIM)
700 13th Street, N.W., Suite 250
Washington, D.C. 20005
(202) 393-1662
JudyAnn Bigby, M.D.
Jeffrey Samet, M.D., M.P.H.

Student National Medical Association (SNMA)
1012 10th Street, N.W.
Washington, D.C. 20001
(202) 371-1616
Daniel LaRoche
Calvin Ayers

The Society of Teachers of Family Medicine (STFM)
8880 Ward Parkway
P.O. Box 88729
Kansas City, Missouri 64114
(816) 333-9700
James Finch, M.D.

INVITED SPEAKERS

Collie F. Brown
The GAINS Center
Policy Research, Inc.
262 Delaware Ave.
Delmar, New York 12054

Nicholas Demos
Chief, Criminal Justice Systems Branch
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration
Department of Health and Human Services
Rockwall II, 10th Floor
Rockville, Maryland 20852

F. Daniel Duffy, M.D., F.A.C.P.
MACY Foundation Conference Report and
Chair, ACGME Residency Review Committee
for Internal Medicine
American Board of Internal Medicine
510 Walnut Street Suite 1700
Philadelphia, Pennsylvania 19106

Michael Fleming, M.D.
Project Director, Substance Abuse Education for
Family Physicians (Project SAEFP)
Department of Family Medicine
University of Wisconsin Medical School
at Madison
777 S. Mill Street
Madison, Wisconsin 53715

Eric Goplerud, Ph.D.
Director, SAMHSA Managed Care Initiatives
Substance Abuse and Mental Health Services Administration
Parklawn Building, Room 12C-10
5600 Fishers Lane
Rockville, Maryland 20857

Alan Henry
Executive Director
Pre-Trial Services Resource Center
1325 G Street, NW
Suite 770
Washington, DC 20005

Kenneth P. Moritsugu, M.D.
Assistant Surgeon General
Medical Director
Federal Bureau of Prisons
U.S. Department of Justice
320 First Streeet, N.W., Suite 1000
Washington, D.C. 20534

Timothy Murray
Director of Policy
Policy and Planning Division
Bureau of Justice Assistance
633 Indiana Ave., NW
Washington, DC 20531

Averette Mhoon Parker, M.D.
Associate Medical Director
Center for Substance Abuse Prevention
Substance Abuse and Mental Health Services Administration
Rockwall II Building 9D-12
5600 Fishers Lane
Rockville, Maryland 20857

Constance M. Pechura, Ph.D.
Institute of Medicine
FO-3022
2101 Constitution Ave., NW
Washington, DC 20418

Suszanne Rohrer M.P.H.
Office for Scientific Analysis and Evaluation
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration
Rockwall II, Suite 840
5600 Fishers Lane
Rockville, Maryland 20857

Amy Rowan, M.D.
American Academy of Child and Adolescent Psychiatry
306 North Narberth Ave.
Narberth, Pennsylvania 19072

Wesley Sowers, M.D.
Speaker - Implications for Co-Occurring Disorders
Medical Director
Center for Addiction Services
St. Francis Medical Center
University of Pittsburgh
400 45th Street
Pittsburgh, Pennsylvania 15201

Beth Weinman, M.A.
Federal Bureau of Prisons
Psychology Department
320 First Street, NW
Washington, DC 20534

H. G. Whittington, M.D.
Speaker - Behavioral Health Consultant
William M. Mercer, Inc.
9614 Bob White Drive
Houston, Texas 77096

INVITED PARTICIPANTS

Hoover Adger, Jr., M.D.
Past-President, AMERSA and
Deputy Director
National Office of Drug Control Policy
Executive Office of the President
Washington, D.C.

J. Harry Isaacson, M.D.
Co-Chair - AMERSA Task Force on Residency Training
Cleveland Clinic Foundation A-91
9500 Euclid Avenue
Cleveland, Ohio 44195

Mark Kraus, M.D.
Co-Chair - AMERSA Task Force on Residency Training
Westside Medical Group, P.C.
714 Chase Parkway
Waterbury, Connecticut 06708

Michael Fleming, M.D.
Project Director, Survey of Residency Training Program Directors
Center for Addiction Research and Training
Associate Professor
Department of Family Medicine
Medical School
University of Wisconsin at Madison
777 S. Mill Street
Madison, Wisconsin 53715

Collie F. Brown
The GAINS Center
Policy Research, Inc.
262 Delaware Avenue
Delmar, New York 12054

Margaret A. E. Jarvis, M.D.
Research Associate
Division of Substance Abuse Medicine
Medical College of Virginia
Box 980109
Richmond, Virginia 23298

John Knight, M.D.
Educator for Interdisciplinary Training in Violence and Substance Abuse
Acting Chief, Blackfon Services
9 East Children's Hospital and Pediatrics Instructor,
Harvard Medical School
300 Longwood Avenue
Boston, Massachusetts 02115

Steven G. Riddell, Ed.D.
Associate Director
National Council of Juvenile and Family Court Judges
P. O. Box 8970
Reno, Nevada 89507

David Rosenbloom, Ph.D.
Join Together
441 Stuart Street
6th Floor
Boston, Massachusetts 02116

Paul Steele
Research Director
Vera Institute of Justice
377 Broadway, 11th Floor
New York, New York 10013

David Warren, J.D.
Executive Director
North Carolina Governor's Institute on Alcohol and Substance Abuse, Inc.
P.O. Box 13374
Research Triangle Park, North Carolina
27709-3374

INVITED GUESTS

Maristela G. Monterio, M.D.
Chief, Treatment and Care
Programme on Substance Abuse
World Health Organization
Geneva, Switzerland
Fax (41 22) 791-4851

Sverre Fauske
Programme on Substance Abuse
World Health Organization
Geneva, Switzerland

Enrique Madrigal
Pan American Health Organization
Washington, D.C.

Marc Galanter, M.D.
Director
Division of Substance Abuse
Nathan Kline Institute
World Health Organization Collaborating Center
Professor of Psychiatry
New York UniversitySchool of Medicine
New York, NY, USA

Ho Young Lee
Fellow
Suwon, Korea

Divanath Samarasinghe
Fellow
Columbo, Sri Lanka

Ulf Rydberg
Fellow
Stockholm, Sweden

Michael Olatawura
Fellow
Ibadan, Nigeria

Marie Claude Hofner
Fellow
Switzerland

FEDERAL REPRESENTATIVES

U.S. Department of Justice (DOJ)

Kenneth P. Moritsugu, M.D.
Assistant Surgeon General
Medical Director
Federal Bureau of Prisons
320 First Street, N.W., Suite 1000
Washington, D.C. 20534
Tel: (202) 307-3055
Fax: (202) 307-0826

Laurie C. Bright
National Institute of Justice
633 Indiana Ave., N.W.
Room 303
Washington, D.C.
Tel: (202) 616-3624
Fax: (202) 307-6394

Shervert Frazier, M.D.
Chief, Psychiatry Services
Federal Bureau of Prisons
Health Services Division
U.S. Department of Justice
320 First Street, N.W., Suite 1000
Washington, D.C. 20534

Cary Mack, Ph.D.
Deputy Chief, Psychiatry Services
Federal Bureau of Prisons
Health Services Division
320 First Street, N.W., Suite 1000
Washington, D.C. 20534

H. Curt Toler, Ed. D.
Chief Psychologist
Psychology Department
Federal Bureau of Prisons
320 First Street, N.W.
Washington, D.C. 20534
Tel: (202) 633-2214
Fax: (202) 724-5848

U.S. Department of Health and Human Services (DHHS)

Sarah Vogelsburg
Drug Policy Advisor
Office of the Secretary
Room 629 H
HHH Building
200 Independence Ave., S.W.
Washington D.C. 20201
Tel: (202) 690-6641
Fax: (202) 690-6167

Substance Abuse and Mental Health Services Administration (SAMHSA)

Nelba Chavez, Ph.D.
Administrator
Parklawn Building, Room12-105
5600 Fishers Lane
Bethesda, Maryland 20867
Tel: (301) 443-4795
Fax: (301) 443-0284

Frank Sullivan, Ph.D.
Director
Office of Policy and Program Coordination
Room 12 C - 06 Parklawn Building
Tel: (301) 443-4111

Susan Salasen
Parklawn Building, Room 15-99
5600 Fishers Lane
Rockville, Maryland 20857
Tel: (301) 443-0001
Fax: (301) 443-5163

Center for Mental Health Services (CMHS)

Bernard Arons, M.D.
Director
Center for Mental Health Services
Parklawn Building, Room 15-99
5600 Fishers Lane
Rockville, Maryland 20857
Tel: (301) 443-0001
Fax: (301) 443-5163

Mel Haas, M.D.
Medical Director
Center for Mental Health Services
Parklawn Building, Room 15-99
5600 Fishers Lane
Rockville, Maryland 20857
Tel: (301) 443-0001
Fax: (301) 443-5163

Paul Wolford, Ph.D.
Center for Mental Health Services
Parklawn Building, Room 15-99
5600 Fishers Lane
Rockville, Maryland 20857
Tel: (301) 443-0001
Fax: (301) 443-5163

Commander G. Bryan Jones
Center for Mental Health Services
Parklawn Building, Room 15C-18
5600 Fishers Lane
Rockville, Maryland 20857
Tel: (301) 443-2132

Center for Substance Prevention (CSAP)

Elaine M. Johnson, Ph.D.
Director
Center for Substance Abuse Prevention
Rockwall II Building 9D - 10
5600 Fishers Lane
Rockville, Maryland 20857
Tel: (301) 443-0365

Vivian L. Smith, M.S.W.
Deputy Director
Center for Substance Abuse Prevention
Rockwall II Building 9D - 10
5600 Fishers Lane
Rockville, Maryland 20857
Tel: (301) 443-0365
Fax: (301) 443-5447

Lucille C. Perez, M.D.
Associate Director for Medical and Clinical Affairs
Center for Substance Abuse Prevention
Parklawn Building, Room 10A-12
5600 Fishers Lane
Rockville, Maryland 20857
Tel: (301) 443-0107
Fax: (301) 443-2317

Ruth Sanchez-Way, Ph.D.
Director
Division of Community Prevention and Training
Rockwall II Building 9D - 10
5600 Fishers Lane
Rockville, Maryland 20857
Tel: (301) 443-0369
Fax: (301) 443-0526

Judy Galloway, J.D.
Public Health Analyst
Division of Community Prevention and Training
Center for Substance Abuse Prevention
Rockwall II Building 9D - 10
5600 Fishers Lane
Rockville, Maryland 20857
Tel: (301) 443-5276
Fax: (301) 443-0526

Center for Substance Abuse Treatment (CSAT)

David J. Mactas
Director
Center for Substance Abuse Treatment
Rockwall II Building, Suite 615
5600 Fishers Lane
Rockville, Maryland 20857
Tel: (301) 443-5700

Camille Barry, Ph.D., R.N.
Deputy Director
Center for Substance Abuse Treatment
Rockwall II Building, Suite 615
5600 Fishers Lane
Rockville, Maryland 20857
Tel: (301) 443-5700
Fax: (301) 443-8751

Jerome Jaffe, M.D.
Director
Office for Scientific Analysis and Evaluation
Center for Substance Abuse Treatment
SAMHSA
Rockwall II, Suite 840
5600 Fishers Lane
Rockville, Maryland 20857
Tel: (301) 443-6549

Sue Rohrer, M.S.N.
Deputy Director
Office for Scientific Analysis and Evaluation
Center for Substance Abuse Treatment
SAMHSA
Rockwall II, Suite 840
5600 Fishers Lane
Rockville, Maryland 20857
Tel: (301) 443-8831
Fax: (301) 480-3144

National Institutes of Health (NIH)

National Institute on Alcohol Abuse and Alcoholism (NIAAA)

Frances Cotter, M.P.H.
Chief
Health Services Research Program
Division of Clinical and Prevention Research
Wilco Building
600 Executive Building, Suite 505
Bethesda, Maryland 20857
Tel: (301) 443-1207
Fax: (301) 443-8774

National Institute on Drug Abuse (NIDA)

Dorynne Czechowicz, M.D.
Medical Officer
Treatment Research Branch
Division of Clinical and Services Research
Parklawn Building, Room 10A-12
5600 Fishers Lane
Rockville, Maryland 20857
Tel: (301) 443-0107
Fax: (301) 443-2317

Uniform Services University of the Health Sciences (USUHS)

Kenneth Hoffman, M.D.
Director
Center For Training and Education in Addiction Medicine
Department of Preventive Medicine and Biometrics
P & B, C-Team
4301 Jones Bridge Road
Bethesda, Maryland 20814
Tel: (301) 295-2642
Fax: (301) 295-2640

Institute of Medicine (IOM)

Constance Pechura, Ph.D.
Director
Division of Neuroscience and Behavioral Health
2101 Constitution Avenue, N.W.
Washington, D.C. 20418
Tel: (202) 334-3387

Health Resources and Services Administration (HRSA)

Claude Earl Fox, M.D., M.P.H.
Administrator
Parklawn Building, Room 14 -05
5600 Fishers Lane
Rockville, Maryland 20857
Tel: (301) 443-2216
Fax: (301) 443-1246

William Robinson, M.D.
Chief Medical Officer
Parklawn Building, Room 14 -39
5600 Fishers Lane
Rockville, Maryland 20857
Tel: (301) 443-0458
Fax: (301) 443-2605

Bureau of Health Professions (BHPr)

Paul Schwab
Acting Director,
Parklawn Building, Room 8-55
Rockville, Maryland 20857
Tel: (301) 443-5704
Fax: (301) 443-2111

Neil Sampson
Deputy Director,
Parklawn Building, Room 8-101
Rockville, Maryland 20857
Tel: (301) 443-6853
Fax: (310) 443-1164

Enrique S. Fernandez, M.D., M.S.Ed.
Director, *Division of Medicine*
Parklawn Building, Room 9A-27
5600 Fishers Lane
Rockville, Maryland 20857
Tel: (301) 443-6190
Fax: (301) 443-8890

John Heyob
Deputy Director, *Division of Medicine*
Parklawn Building, Room 9A-27
5600 Fishers Lane
Rockville, Maryland 20857
Tel: (301) 443-6190
Fax: (301) 443-8890

Carol Bazell, MD
Chief, *Primary Care Medical Education Branch*
Division of Medicine
Parklawn Building, Room 9A-27
5600 Fishers Lane
Rockville, Maryland 20857
Tel: (301) 443-6190
Fax: (301) 443-8890

Ruth Kahn, D.N.Sc.
Health Professions Education Specialist
Primary Care Medical Education Branch
Division of Medicine
Parklawn Building, Room 9A-27
5600 Fishers Lane
Rockville, Maryland 20857
Tel: (301) 443-6823
Fax: (301) 443-8890 or 1945

Stan Bastacky, D.M.D.
Chief, Special Projects and Data Analysis Branch
Division of Medicine
Parklawn Building, Room 9A-27
5600 Fishers Lane
Rockville, Maryland 20857
Tel: (301) 443-6785
Fax: (301) 443-8890

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I. EXECUTIVE SUMMARY

This Executive Summary of the *Second Policy Report of the Physician Consortium on Substance Abuse Education* reemphasizes the purpose of the Physician Consortium on Substance Abuse Education (the Consortium) and presents the consensus statements of the findings and recommendations of Consortium members, achieved during their most recent meeting. The Consortium recommendations contained in its first *Policy Report* stimulated significant changes in graduate medical education. Important barriers remain to be overcome before the Nation can achieve a system of care that responds to the needs of all segments of the population. The barriers are particularly difficult in relation to the complex connections between substance abuse and criminal conduct and between medical treatment for substance abuse and the criminal justice system.

This report, presented with a sense of urgency, puts forward a bold set of recommendations intended to alter the complex connections in a positive way, in order to reduce and, if possible, eliminate the barriers that exist between two separate systems. The report provides an overview and the thrust of the deliberations of Consortium members during its most recent meeting. The recommendations contained in this *Second Policy Report of the Physician Consortium on Substance Abuse Education* define specific improvements needed in medical education to clarify the role of the physician in the working relations between the health care and the criminal justice systems. The findings leading to the recommendations are cited as well. The report concludes with background information about the broad problem of substance abuse and descriptions of current approaches to substance abuse being used within the criminal justice system.

Purpose of the Physician Consortium

The Physician Consortium is challenged to examine new avenues and offer recommendations for education and training that promote the role of the physician in prevention, early detection, diagnosis, treatment and referral for substance abuse. With its most recent meetings, the Consortium broadened its approach to medical education by meeting with professionals representing the criminal justice system. This expanded approach was chosen to develop new strategies in education and training that could have a positive impact on issues of mutual concern associated with crime and substance abuse.

The Consortium was asked originally to assess the educational needs of physicians, to identify the barriers that prevent physicians from treating the problems associated with substance abuse and to make recommendations for needed change in the education and training of physicians, change that would extend to curricula of medical schools and residency programs as well as continuing medical education. That charge remains valid and continues to be the focus of Consortium deliberations.

Consortium Consensus on Findings

The central point on which all of the Consortium participants agreed is the urgent need for joint education and training that would affect the types and quality of health care services delivered to persons with substance abuse problems within the context of the criminal justice system. That agreement is summarized as follows: *Physicians and other health professionals should join with judges and other criminal justice professionals in discussions and training programs aimed at enlightening each group about the perspectives of the medical and criminal justice worlds concerning the substance abusing population, especially that sector of the population that is incarcerated or has been charged with a crime.*

The Consortium agreed further that there is an urgent need for a National Medico-Legal Conference on Substance Abuse Education. The Conference would permit the medical and criminal justice communities to work together on design of policy, training and programmatic approaches to improve the management of substance abuse.

This need for some way for medical and criminal justice professionals to come together was evident to all of the participants in the several meetings held by the Consortium to discuss the subject. Briefings delivered to Consortium members on the operations of the criminal justice system regarding substance abusers were well received by the physician members, many of whom had little prior knowledge of that system.

Physician Consortium Recommendations

The most important recommendation emerging from the conference is the need for joint discussion and training opportunities for professionals in the medical and criminal justice systems. This theme of joint training is included in a number of the recommendations outlined below. While the main body of the report provides more detailed information on the deliberations and findings of the Consortium members, the recommendations of the Consortium are summarized below.

Broad System Recommendations

1. Organize joint American Bar Association/American Medical Association (ABA/AMA) action committees either nationally or at the State level to devise actions that could be promoted locally or nationally to address the considerable inadequacies noted under the section on system findings.

2. Both public and private efforts are essential to gain the media attention and other publicity required to gain the financial and other resources adequate to support community-based systems of treatment.

3. Organizations such as the Institute of Medicine (IOM) and the General Accounting Office (GAO) should undertake studies of the present inadequacies and potential systemic solutions.

4. To facilitate effective interdisciplinary planning and action, community-based coalitions should be formed that include the medical community and the criminal justice community. A possible model for this approach is the national community coalition development program designed by the Center for Substance Abuse Prevention (CSAP).

Service System Recommendations

1. The Physician Consortium should advocate the development and adoption of access and outcome standards for substance abuse care within the context of the criminal justice system.

2. The Physician Consortium should collaborate with Federal agencies and national organizations to bring attention to the significance of co-occurrence of mental illness and substance use disorders within criminal justice settings.

3. "Healthy People 2010" should include the standards and services needed for effective care for persons with substance abuse problems in the context of the criminal justice system.

4. Managed care contracts for the criminal justice system should incorporate standards for addiction care generally and for care within the context of the corrections system, stressing the need for effective care of substance abuse problems after release from the criminal justice system.

5. Continuity of care standards should be built into all health care management approaches, so that those persons who are discharged can obtain continued substance abuse treatment. Physicians must take the lead in insisting on such standards and on their development.

6. The service systems need to include provision for potentially more cost-effective approaches, such as early intervention and targeting of certain categories of offenders such as juveniles.

7. All detention centers in the country should have access to comprehensive substance abuse screening/detection programs.

Education and Training Recommendations

1. The recommendations contained in the 1991 *Policy Report of the Physician Consortium on Substance Abuse Education* should be implemented as soon as possible.

2. Both the medical education system and the criminal justice system need to accept collaborative responsibility for the education and training of professionals in their respective systems. Consortium members should help to organize integrated education and training for students/residents, lawyers, judges and criminal justice professionals.

3. Integrated education and training for medical students and residents, lawyers, judges and other criminal justice professionals should be provided. Education should include exposure to integrated components of the criminal justice system such as Drug Courts, Pre-Trial Services and Community Coalitions.

4. Criminal justice professionals need to be trained in the medical model. Consortium members believe strongly that criminal justice system professionals and health care professionals should be trained in joint sessions to become more aware of the needs and operating standards in both fields and to promote interdisciplinary approaches.

5. Existing coalitions and operational venues should be used as education and training opportunities. Two major examples would be Drug Courts and CSAP's Community Coalitions.

6. Examinations taken by both medical students and residents should include questions on the criminal justice system and substance abuse. Medical schools and residencies should include more education and training to prepare students and residents in this area.

7. The Consortium should advance the awareness among health care professionals working with adult and adolescent clients involved in the criminal justice system regarding the significance of the co-occurrence of mental illness, substance abuse, HIV/AIDS and tuberculosis.

8. In addition to the normal testing that accompanies the undergraduate and graduate medical education processes, it is important to recognize the importance of continuing medical education and the periodic recertification of health professionals. Material on substance abuse should be built into both continuing education courses and the certification processes to improve knowledge, attitudes, and skills.

Consortium History

The Physician Consortium on Substance Abuse Education was organized in 1989 under the aegis of the Public Health Service, Health Resources and Services Administration, Bureau of Health Professions, Division of Medicine, to examine substance abuse education for physicians at all levels of training. The establishment of the Physician Consortium was an outcome of earlier alcohol abuse initiatives of the Office of the Secretary, Department of Health and Human Services. In 1988 two meetings were held with physician representatives of medical organizations and representatives of the Federal Government to discuss the alcohol training and education needs of the physician community and the role of licensure examinations in assuring a minimum level of physician competence in the area of alcohol diagnosis and intervention.

In 1989 the Director of the Bureau of Health Professions, working in collaboration with the American Medical Association, held an invitational conference to discuss the topic *"The Primary Care Physician's Critical Role in Preventing Alcohol Abuse and Alcoholism"*. Also during this time period, the Public Health Service issued the *"Year 2000 Draft Objectives for Reducing Alcohol and Other Drugs"* and established a Task Force on Illicit Drugs. In response to the clearly identified need for better educated and trained health professionals, the Bureau of Health Professions established health professional consortia to focus on the education and training needs of practitioners in the area of substance abuse.

The Physician Consortium on Substance Abuse Education was formed by expanding the membership of the previous working groups to include organizations responsible for physician training and education. This newly constituted consortium, which included representatives nominated by their medical associations, societies, specialty boards, and medical schools, met for the first time in June 1989, under the auspices of the Bureau of Health Professions, Division of Medicine. Subsequent meetings of the Consortium were held in 1995 to discuss physician education in the context of managed care and the federal prison system and in 1996 to discuss more comprehensively the topic of physician education in relation to the issues at the interface of the health and criminal justice systems.

Consortium Goal

The Physician Consortium's goal continues to support the several "Healthy People" reports of the Department of Health and Human Services[1] that define health objectives for the Nation. Those objectives aim to sharply reduce drug abuse and the high toll it exacts on the American people. Its 1991 *Policy Report of the Physician Consortium on Substance Abuse Education* contributed substantially to improved understanding of the physician's role in medical issues associated with substance abuse. That report, along with the national efforts of medical organizations, stimulated significant changes in graduate medical education of all primary care physicians.

Unfortunately, substance abuse remains among the Nation's leading medical and social problems. Physician training must be expanded to include greater contextual understanding of the problem and to integrate medical services more effectively into the services connected with the criminal justice system, which is often the first point of contact with substance abusers.

Consortium Agenda and Approach to Work

The Second Policy Report of the Physician Consortium on Substance Abuse Education is the product of the last two years of work by the Consortium. This second *Policy Report* presents in full the Consortium's findings on medical education in substance abuse at the sectors of interface of the health and criminal justice systems. The report makes recommendations for improving the

1. Healthy People 2000, National Health Promotion and Disease Prevention Objectives (DHHS, 1991) and the recent Secretary's Council on Health Promotion and Disease Prevention Objectives for 2010 (DHHS, 1997).

quality of medical education and the ability of physicians to work more effectively with professionals in the several parts of the criminal justice system, including the police, the courts and the local, state and federal detention systems. This *Policy Report* is intended for widespread circulation to national medical organizations and to Federal and State agencies for their use in supporting the education of physicians to overcome the barriers to effective treatment of substance abuse.

II. THE PHYSICIAN CONSORTIUM ON SUBSTANCE ABUSE EDUCATION

The Physician Consortium on Substance Abuse Education (Consortium) brings together representatives of leading substance abuse organizations, specialty boards and societies, medical education associations and groups with Federal representatives to discuss issues and problems of common interest. The Consortium makes recommendations for changes and improvements in physician education intended to enable physicians to intervene effectively in prevention, early identification, treatment and referral of patients who have a substance abuse problem. Two agencies in the U.S. Department of Health and Human Services—the Health Resources and Services Administration (HRSA) and Substance Abuse and Mental Health Services Administration—support the Consortium. Staff support is provided to the Physician Consortium by HRSA's Bureau of Health Professions" Division of Medicine.

Outcomes of the 1995/96 Consortium Deliberations

Since its first policy report, the Physician Consortium has been working to expand its policy recommendations regarding the challenges and opportunities for physicians to become better educated in the art of diagnosis and treatment of persons engaged in substance abuse behaviors. Having achieved significant success in expanding graduate medical education to include basic substance abuse diagnosis and treatment, the Consortium began to focus on the problems of substance abuse within the context of the criminal justice system.

During meetings in October 1995 and December 1996, the Consortium held discussions that are part of a planned series in a joint initiative of the Secretary of the Department of Health and Human Services and the Attorney General aimed at development of more effective approaches to the confluence of issues related to crime and substance abuse in our Nation.

During these meetings it became clear that the two worlds of medicine and criminal justice intersect, but only minimally. A common understanding of the two perspectives is infrequently achieved, due to different objectives of the professionals operating in these two worlds. The central point of additional physician education and training would be to break down the walls between the two worlds, so that appropriate medical care could be made available on a systematic basis in concert with the criminal justice system.

Perhaps the central point on which all of the Consortium participants agreed is the need for joint education and training. That agreement is summarized as follows.

Physicians and other health professionals should join with judges and other criminal justice professionals in discussions and training programs aimed at enlightening each group about the perspectives of the medical and criminal justice worlds concerning the substance abusing population, especially that sector of the population that is incarcerated or has been charged with a crime.

The consensus on joint activities extended to a consensus on the perceived importance of a National Medico-Legal Conference on Substance Abuse Education. The Conference would permit the medical and criminal justice communities to work together on design of policy, training and programmatic approaches to improve the management of substance abuse.

While most Consortium members recognized the need for physicians to be trained in both addictions and the criminal justice system, there was equal recognition of the need for criminal justice professionals to be trained in the medical aspects of substance abuse. Joint education and training was a common need cited by Consortium members and criminal justice integrated action by "communities" not used to working together. While the Consortium members advanced many specific recommendations, major action steps to be taken by Consortium members were defined and agreed upon.

1. **The Consortium should take steps to advance standards of care for people who present in the criminal justice system with substance abuse problems.**

   Consortium participants agree generally that education of physicians should be preceded by the development of standards of care. The American Psychiatric Association has developed and is updating its own standards of care for substance abusers in criminal justice settings, and the National Commission on Correctional Health Care has expressed its support for standards for substance abuse treatment. Standards formed on the basis of a desire to reduce health care costs alone are inadequate. Further, the issues of diagnosis and treatment of addiction are complicated by multiple problems and by the behavior of criminal addicts that can differ from other non-criminal addicts. Finally, cost-effective treatment is as much a systems problem as a medical problem and requires coordinated action by health professionals and criminal justice professionals.

2. **The Consortium should argue forcefully for the education of physicians and criminal justice professionals in joint training sessions in the psychology and the diagnosis and treatment of substance abuse problems.**

   Physicians, police, judges, and corrections officers live and work in different communities and employ different approaches to the persons who present themselves for action or treatment. Much of the difference in approaches can be explained by different objectives in the two communities. To the extent that solutions to crime and drug addiction can be found through joint action, it is necessary that the entire range of professionals understand the objectives, the language and the approaches of other professionals working on the same problems.

3. **The Consortium should seek to educate legislators and budget officials on cost-effective approaches to care.**

   Budget officers in the Executive Branch of government and members of Congress sometimes favor policies that are based on short-term cost savings, objectives that may create unintended long-range, adverse health system consequences. The Consortium needs to work with these officials and with the public at large to encourage the adoption of more broadly cost-effective long-range policies.

4. **The Consortium should argue for joint community medical-criminal justice coalitions to attack the problems of substance abuse within communities.**

   The Center for Substance Abuse Prevention (CSAP) has been working for several years on the development of community coalitions that are intended to marshal community resources in the fight against substance abuse. Such coalitions (e.g., Join Together, Fighting Back) often do not include adequate representation from the medical community and may not even include appropriate members of the criminal justice community. The Consortium should advocate a greater participation by medical and criminal justice professionals in these coalitions.

5. **The Consortium should invite the American Bar Association (ABA) and the American Medical Association (AMA) to form joint committees at national and local levels to promote joint training and more effective standards of addiction care.**

   Consortium members argue the need for more pressure from the top to assure that more effective standards are developed. National and local legal and medical associations, working together, can provide a

powerful stimulus to action by communities, educational institutions and even legislative bodies.

6. **The Consortium should argue against use of "behavioral carve-outs" for dealing with substance abuse generally and criminal justice addiction problems more specifically.**

Such carve-out arrangements can lead to a disintegration of health services for substance abusers. These "carve-outs" are likely to develop in an increasingly proprietary managed care environment, in which the primary concern may be seen as profit and cost-management.

7. **The Consortium should take steps to build a greater level of understanding about the special problems involved in treating persons who are both substance abusers and mentally ill.**

Health care professionals working with adult and adolescent clients involved in the criminal justice system are often insufficiently aware of the significance of the co-occurrence of mental illness, substance abuse, HIV/AIDS and tuberculosis. Particular attention needs to be paid to women's health issues, which represent a growing problem within the criminal justice system.

III. CONSORTIUM DELIBERATIONS

The Role of Judges in the System

The judge is so central to the criminal justice system that it is necessary for physicians to understand his/her role. Judges proceed through a series of steps, each with its own objectives—*"Does the person understand why he is before the judge; does he know his rights; is he properly represented by counsel?"* Then the judge moves the case forward—what is he to do with the person before him? The judge's primary objective at this point in the system is to assure the safety of the community. *"Will this person who has been brought before me after being arrested return to the court if I release him; if he is released, will he create further harm to the community?"* Only after being assured on these questions, will a judge turn his attention to other issues, for example, *"what course of action is best for the arrestee?"*

During the initial stage of processing persons charged will not be brought to trial generally for at least six months. Judges must decide what should happen to the person during that time period. To assist the judge in making his decision, various attempts have been made to arm the judge with information. Pre-Trial Services is one of those approaches. Pre-Trial Services programs obtain information about the person. Relying on past statistical relationships known through research, the programs provide recommendations to the judge. In cases in which drugs are involved the issue of release is complicated. The types of drugs being used, the number of drugs being used and the history of use/abuse all play a role in shaping the judge's final decision. Pre-trial release is the basic decision facing the judge.

The current conditions in most jails—where a person will be detained pending his trial—are so relatively difficult due to overcrowding that judges are anxious for some way to release the person. Again, safety and the dependability of the release mechanism are key criteria. Treatment availability can help to decide in favor of release. Note that rehabilitation of the person is not the issue—getting him sufficient treatment so that he does not return to using or needing to use drugs is the major objective. To the extent that the person remains drug-free during the pre-trial release period, the person will remain free. A return to drug use will trigger a return to the judge and, likely, a trip to the local, overcrowded jail.

Pre-Trial Programs

What is being learned through experience with people during this pre-trial period is that the amount and quality of treatment made available can affect the outcome of the entire process. Pre-trial diversion programs were borne out of the recognition that keeping people out of the core criminal justice system is one of the most effective ways to reduce subsequent problems. The criminal justice system is described as "criminogenic"; that is, the longer people remain within the system the worse it can be for them. Diversion began experimentally in the 1920's and was renewed during the 1970's. Conceptually, diversion programs work through a contract of sorts. The arrestee agrees to enter a drug treatment program and remain in that program for six months. If the person completes the program successfully, the charges are dropped and the person regains his freedom. People who have been arrested on a minor narcotics charge and who have no prior record are good candidates for such programs.

Drug Courts

To cope with the continued rush of people who are arrested on drug charges, a new system of Drug Courts was developed and has grown to include approximately 200 communities. Drug Courts, although a part of the regular court system, are intended to provide a separate track for alternative disposition of cases involving drug offenders. People who are arrested on drug charges, or where drugs are involved, may be shifted into a Drug Court for consideration of their case. Drug Courts are intended to find a different outcome than the revolving door system that characterizes the regular criminal justice system

approach to drug possession cases. With Drug Courts, people come before a judge who, if the arrestee satisfies the judge about his intent, will assign the person to a drug treatment program instead of jail or prison.

During this period the drug court judge has the primary role in overseeing and supporting the defendant's positive response to drug treatment, testing and supervision. The judge heads a drug court team composed of a prosecutor, a public defender, a case manager and a treatment coordinator who operate in a supportive, non-adversarial process. To the extent that the judge is armed with useful information, and to the extent that adequate treatment services are available, the judge can succeed in causing the person arrested to modify his behavior, at least for a while. If people insist on continuing to use drugs, the judge will remove them from this special program and return them back to the normal criminal justice system.

The Prison System

After a trial and final adjudication persons who are arrested may move into a different system and out of the control of judicial case managers. The jail/prison system's objective is primarily safety of the community. Persons who are incarcerated are not patients—they are prisoners. Addiction treatment is the exception, not the rule. One of the major problems faced by halfway houses that accept persons who have been released from prison is the need to treat their addiction problems. Some prisons have adequate health care facilities—indeed the Federal Bureau of Prisons health care system has a relatively complete range of facilities. A system of correctional medicine is being developed, including new residencies, and is supported by such professional organizations as the National Commission on Correctional Health Care and the National Correctional Health Care Association. However, the capacity of the current physician education and training system related to health care within the criminal justice system is very limited and would need to be supplemented in the case of an expanded demand.

After-Care

To the extent that persons are addicted upon entering prison, they will likely require care after leaving prison. One of the difficulties experienced in attempting to provide after-care is that most treatment systems, especially those involving insurance, now have treatment caps that are incompatible with the needs of the substance abusing population. Given the rising prison population associated with drug charges, we can expect a rising population of people who require after-care treatment. Absent such a treatment system, we may be at risk of building a gradually expanding revolving door system, with increasing costs of administration and no hope of escape.

Potential Intersections

Figure 1 illustrates a vastly simplified representation of the criminal justice system as it relates to substance abuse. Four areas of possible intersection between criminal justice and medicine are defined.

Area # 1—The initial stage from immediately after arrest to the initial stage of information collection about the person and decision about initial disposition of the case. Many arrests result in an emergency room (ER) visit, in which physicians and police interact, although with vastly different objectives. The ER often is the first point of intersection.

Area # 2—The process by which an arrestee is diverted into a treatment program. This process provides an opportunity in which physicians and other treatment personnel can collaborate to produce a more holistic approach to care for people who are often afflicted with multiple problems.

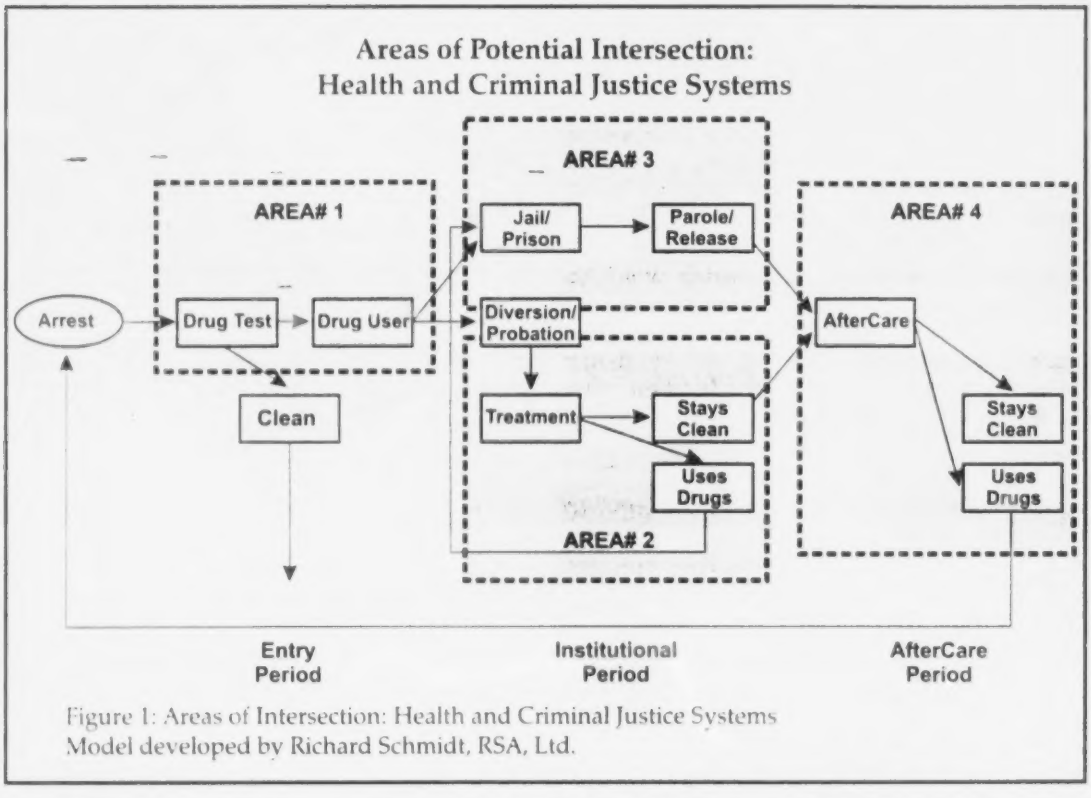

Figure 1: Areas of Intersection: Health and Criminal Justice Systems
Model developed by Richard Schmidt, RSA, Ltd.

Area # 3—The period of incarceration in jail or prison also presents an opportunity for cost-effective treatment of multiple problems.

Area # 4—The period after prison and even after release from a treatment program may be an opportunity not only to treat former prisoners who need a variety of health care interventions, but to offer a service that might keep them from repeating their earlier mistakes.

Barriers to Effective Treatment

Health care professionals attempting to treat the multiple problems experienced by most substance abusers face formidable barriers. They include conflicting systems objectives, professionals who have vastly different perspectives, lack of education and training for many of the professionals who care for substance abusers and inadequate resources.

Perhaps the most important problem is the attitude of most Americans toward persons who are in trouble with the law, particularly when they are addicted to illegal drugs. Such persons are regarded as personally, even willfully inadequate with regard to drugs. They are viewed as hostile and sometimes threatening to people who attempt to help them. And they are overwhelmingly poor.[2]

2. Treatment of the low-income drug addict is contrasted with the experiences of many professionals, including especially health care professionals, whose addiction is treated as a health problem subject to successful intervention and whose privacy is assured as a normal part of the system.

Medical students and residents are anxious to learn how to be skillful physicians. The learning process is complex, and new information is added each year because of advances in medical technology and knowledge. Each new set of findings or each newly labeled group in need of care present both new opportunities and new challenges to medical students and to medical faculty. The medical school educational process has a finite number of hours within which to complete the education of medical students. All changes to the curricula of medical schools for undergraduate education and the residency programs for graduate medical education must compete for space with all of the other worthy and necessary components of the educational process.

Each group claims, with some accuracy, that physicians are inadequately trained—gerontology, nutrition, addiction are all areas of health care that warrant attention. Criminal justice is a potential additional competitor. To succeed in adding material to the curriculum requires a confluence of professional advocacy, mutually shared interests, perceived importance and recognition of the need in terms of national visibility.

IV. FINDINGS OF THE PHYSICIAN CONSORTIUM

Having listened to several presentations on how the criminal justice system operates with respect to the use and abuse of illicit drugs, Consortium members considered the implications of the information in the context of systems changes and changes in the education and training of physicians. Many of the current findings and recommendations support earlier recommendations contained in the 1991 *Policy Report of the Physician Consortium on Substance Abuse Education*. Other findings and recommendations will require further consideration, perhaps even debate among Consortium participants in another national meeting.

One of the more significant findings concerns the need for collaborative educational ventures and the development of model training programs. Medicine cannot proceed independently and expect to be successful. Rather, integrated discussions are needed to assure effective working relationships and improved outcomes. The central issues that need to be addressed are defined below under the broad topics, *Systems, Services, and Education and Training*.

Systems Findings

1. Public and political support are currently inadequate to produce more cost-effective approaches to medical care for addicts generally and criminal offenders specifically. Such support requires formal advocacy and well-designed public campaigns.

2. Substance abuse is not viewed and acted upon currently from both a public health and a public safety perspective. In this regard, both medical and criminal justice professionals need to adopt such a dual perspective, shaping a common language to assure that they will, at a minimum, support joint efforts at effective substance abuse interventions.

3. The criminal justice system lacks adequate resources to conduct routine, comprehensive screening and treatment for its inmate population relative to substance abuse and the accompanying psychosocial and physiological problems.

4. Most communities lack adequate interdisciplinary planning and action agencies to develop and oversee effective approaches to dealing with substance abuse. The CSAP national community coalition development program might be a useful model.

5. Short-term budget issues often dictate the design of approaches to problems such as substance abuse. Such approaches appear frequently to be ineffective, contributing to other longer-range problems—higher crime rates and incarceration of people who might be kept out of the criminal justice system by earlier treatment. It has become clear that legislators, their staffs, budget planners in OMB and the main departments of government need to receive orientation in effective approaches to addiction treatment.

6. While it is vital that prevention and treatment programs be accompanied by studies of their efficacy, it is equally important that the effective approaches be publicized through positive media messages.

7. Perceptions of the high costs associated with effective treatment approaches are problematic because of the current demand that criminals not be "coddled." Frequently it is less the general public than special political interest groups that are the most adamant concerning such views.

8. Because costs rather than outcomes have come increasingly to dominate debates about social problems, low-cost approaches are often favored over more expensive solutions.

One result in the medical arena has been the growth in low-cost, relatively low-quality medical care establishments, with predictably poor outcomes.

9. As many as 10 million people enter or leave the correctional system each year. To the extent that population is ignored, the consequences may well include higher downstream bills in terms of medical care, crime and the costs of subsequent incarceration.

10. The health care system and the criminal justice system do not always operate in synchronous harmony due to their different objectives. One mission of the criminal justice system is to clear out the backlog of people waiting to be processed or released. That population keeps returning to the community in need of services but lacking the means to purchase the needed care. Lacking treatment, that population often returns to illegal activities. Thus, the longer their need for treatment is ignored, the larger becomes the lifetime bill. Lifetime caps on treatment costs and time tend to exacerbate this issue.

11. The need for educated physicians runs parallel to the need for funds to pay for health services for persons with substance abuse problems. Without adequate education, physicians may not be able to diagnose and treat effectively. Yet, if they become trained and can diagnose properly, can they afford to treat patients if the resources are inadequate?

12. The judge serves as a case manager in the criminal justice system regarding persons who have been brought before him for substance abuse problems. To serve in that capacity effectively, the judge requires accurate and comprehensive information about the options available in the community for diagnosis and treatment. Physicians are infrequently consulted in providing this type of information. After-care for substance abuse problems is of special concern to prevent the common problem of recidivism.

13. The objective of many parts of the criminal justice system is to move people through and even out of the system. Security—protection of the community—is the main standard, but getting people out of the system—reducing backlog—is also important. This need for rapid processing of people probably impedes effective diagnosis and treatment.

14. Public and political support are necessary elements in obtaining the support needed to accomplish a full integration of medicine and justice and to provide the funding required for adequate care to be delivered. Much of the research on the subject of addiction is based on small studies of uncertain validity. The concerned sectors—legal, medical, and community development—do not work together currently on the scale needed to mount fully successful research projects for the purpose of synthesizing existing research to assure consistent application of research findings.

15. When persons are incarcerated within the criminal justice system, medical care is available to them for long periods. Yet, when they are outside that system, suddenly they face lifetime limits on care, 28-day limits on inpatient care, etc. Policy officials and the public at large do not adequately understand the need for long term care for people who are addicted, nor the increased costs that could be incurred by not providing that care.

Service Findings

1. There is currently an inadequate body of knowledge regarding standards of care for substance abusers broadly and for special populations such as adolescents, pregnant women or their families. Such standards as now exist represent insurance coverage limits, rather than effective medical standards.

The gaps in knowledge extend to other related fields, such as prevention programs, which may be pursued and promoted despite the absence of evidence supporting efficacy.

2. The current systems of care for persons who are substance abusers are disjointed and often operate at odds with their needs. The criminal justice system operates over capacity much of the time and moves people through and out of the system at a relatively rapid pace, often unable to meet their need for treatment of multiple health problems. Similarly the civilian medical care system, because of insurance limitations, moves people through and out of that system at the same pace, often well before their substance abuse problems can be resolved.

3. Inadequate opportunities exist presently for health professionals and criminal justice professionals to share perspectives regarding effective care of criminal offenders.

4. Consortium members discussed the paucity of information concerning the availability of comprehensive, integrated psychiatric and substance abuse service programs nationwide. A model for such a program was identified by Consortium members as a psychiatric program at Bellevue Hospital in New York.

5. There appear to be few standards of care, especially in behavioral care "carve-outs." "Carve-outs" may not be adequate for dealing with subjects such as substance abuse because they tend to promote low cost as the dominant criterion of service, and they inhibit more holistic approaches to care.

6. When advocates argue for expanded mental health treatment, they generally exclude substance abuse. They tend to see substance abuse as a life-style choice rather than a disease.

7. Standards of care are lacking for addiction care generally, and more specifically for care within the context of the corrections system. This gap includes standards for effective after-care treatment, so that persons can continue to receive needed care after they return to the community.

8. There is an accepted body of research confirming the co-occurrence of mental illness and substance abuse disorders among prisoners confined in the criminal justice system. Nevertheless, service delivery systems continue to function in ways that do not promote integration or effective use of limited resources to serve this affected population.

Education and Training System Findings

1. Physicians lack education and training relevant to the criminal justice system, in order to understand how to help substance abusers who are in or who have been released from that system.

2. Physicians remain inadequately trained in substance abuse, especially in the psychology of addiction. Juveniles, for example, rarely admit to use. Only 6% of those who are asked admit to use, while 67% of juvenile offenders test positive.

3. Medical education and training currently do not provide sufficient opportunities for students to gain insights into community issues regarding crime and substance abuse.

4. After-care is seriously lacking for substance abusing patients. Physicians presently are not trained in the standards of effective treatment for such care.

5. Practicing medicine in a criminal justice context requires careful attention to culture.

Medical education and training currently are inadequate with regard to cultural issues, which are profound in the community of people who are both addicted and criminal offenders. Cultural sensitivity skills are difficult to acquire.

6. Significant gaps exist in the education and training of criminal justice professionals, including the judiciary, district attorneys, probation officers and other judicial officials regarding such medical issues as substance abuse and dual diagnosis.

7. Little specialty education and training and few fellowships are available in correctional health care nationally. Few trained faculty are available to direct such training and fellowships.

8. The core knowledge required by both correctional physician-specialists and by primary care physicians who occasionally treat criminal offenders is not well defined currently.

V. RECOMMENDATIONS OF THE PHYSICIAN CONSORTIUM

Broad System Recommendations

1. Organize joint ABA/AMA action committees either nationally or at the State level to devise actions that could be promoted locally or nationally to address the considerable inadequacies noted under the section on system findings.

2. Both public and private efforts are essential to gain the media attention and other publicity required to gain the financial and other resources adequate to support community-based systems of treatment.

3. Organizations such as the Institute of Medicine (IOM) and the General Accounting Office (GAO) should undertake studies of the present inadequacies and potential systemic solutions.

4. To facilitate interdisciplinary planning and effective action, community-based coalitions should be formed that include the medical community and the criminal justice community. A possible model for this approach is the national community coalition development program designed by the Center for Substance Abuse Prevention (CSAP).

Service System Recommendations

1. The Physician Consortium should advocate the development and adoption of access and outcome standards for substance abuse care within the context of the criminal justice system.

2. The Physician Consortium should collaborate with Federal agencies and national organizations to bring attention to the significance of co-occurrence of mental illness and substance use disorders within criminal justice settings.

3. "Healthy People 2010" should include the standards and services needed for effective care for persons with substance abuse problems in the context of the criminal justice system.

4. Managed care contracts for the criminal justice system should incorporate standards for addiction care generally and for care within the context of the corrections system, stressing the need for effective care of substance abuse problems after release from the criminal justice system.

5. Continuity of care standards should be built into all health care management approaches, so that those persons who are discharged can obtain continued substance abuse treatment. Physicians must take the lead in insisting on such standards and on their development.

6. The service systems need to include provision for potentially more cost-effective approaches, such as early intervention and targeting of certain categories of offenders such as juveniles.

7. All detention centers in the country should have access to comprehensive substance abuse screening/detection programs.

Education and Training Recommendations

1. The recommendations contained in the 1991 *Policy Report of the Physician Consortium on Substance Abuse Education* should be implemented as soon as possible.

2. Both the medical education system and the criminal justice system need to accept collaborative responsibility for the education and training of professionals in their respective systems. Consortium members

should help to organize integrated education and training for students/residents, lawyers, judges and criminal justice professionals.

3. Integrated education and training for medical students and residents, lawyers, judges and other criminal justice professionals should be provided. Education should include exposure to integrated components of the criminal justice system such as Drug Courts, Pre-Trial Services and Community Coalitions.

4. Criminal justice professionals need to be trained in the medical model. Consortium members believe strongly that criminal justice system professionals and health care professionals should be trained in joint sessions to become more aware of the needs and operating standards in both fields and to promote interdisciplinary approaches.

5. Existing coalitions and operational venues should be used as education and training opportunities. Two major examples would be Drug Courts and CSAP's Community Coalitions.

6. Examinations taken by both medical students and residents should include questions on the criminal justice system and substance abuse. Medical schools and residencies should include more education and training to prepare students and residents in this area.

7. The Consortium should advance the awareness among health care professionals working with adult and adolescent clients involved in the criminal justice system of the significance of the co-occurrence of mental illness, substance abuse, HIV/AIDS and tuberculosis.

8. In addition to the normal testing that accompanies the undergraduate and graduate medical education processes, it is important to recognize the importance of continuing medical education and the periodic recertification of health professionals. Material on substance abuse should be built into both continuing education courses and the certification processes to improve knowledge, attitudes and skills.

VI. BACKGROUND OF THE SUBSTANCE ABUSE PROBLEM

Substance abuse continues to be one of the most serious threats to the health and well being of Americans. Abuse of tobacco, alcohol and other drugs is common. Tobacco use is responsible for more than one of every six deaths in the United States and is the most important single preventable cause of death and disease in our society. Yet, nearly one-third of all adults in the United States continue to smoke—an estimated 62 million Americans were current smokers in 1996. This represents a smoking rate of 29 percent. Current cigarette smoking did not change between 1995 and 1996.

Among youths age 12-17 rates of smoking did not change between 1995 and 1996. An estimated 18 percent of youths age 12-17 (4.1 million adolescents) were current smokers in 1996. During 1995 about 1.7 million Americans first became daily smokers.

In 1996 an estimated 13.0 million Americans were current illicit drug users, meaning they had used an illicit drug in the month prior to interview. This represents 6.1 percent of the population 12 years old and older.

Marijuana is the most commonly used illicit drug, used by 77 percent of current illicit drug users. Approximately 54 percent of current illicit drug users used marijuana only, 23 percent used marijuana and another illicit drug, and the remaining 23 percent used only an illicit drug other than marijuana in the past month. Therefore, about 46 percent of current illicit drug users in 1996 (an estimated 5.8 million Americans) were current users of illicit drugs other than marijuana and hashish.

The number of current illicit drug users did not change significantly between 1995 and 1996 (12.8 and 13.0 million, respectively). The number of current illicit drug users was at its highest level in 1979 (25.4 million, 14.1 percent), declined until 1992 (12.0 million, 5.8 percent) and has remained at approximately the same level since then.

Rates of use of drugs such as marijuana, psychotherapeutics, cocaine, inhalants or hallucinogens in the total population age 12 and older did not change significantly between 1995 and 1996.

Rates of drug use show substantial variation by age. Among youths age 12-13, 2.2 percent were current illicit drug users. The highest rates were found among young people ages 16-17 (15.6 percent) and age 18-20 (20.0 percent). Rates of use were lower in each successive age group, with only about one percent of persons age 50 and older reporting current illicit use.

Half of young adults age 21-25 had tried illicit drugs at least once in their lifetime, and 13 percent were current users. More than half of adults age 26-49 had tried illicit drugs, but rates of current use were only 8.4 percent for those age 26-34 and 5.2 percent for those age 35-49.

The percentage of current illicit drug users who were age 35 and older increased from 10.3 percent in 1979 to 26.1 percent in 1990. Between 1990 and 1996 the percentage remained fairly constant (28.3 percent in 1996).

The percentage of adolescents (12-17 years old) using drugs decreased between 1995 and 1996 after several years of increase. In 1992 the rate of past month use among youth age 12-17 reached a low of 5.3 percent, the result of a decline from 16.3 percent in 1979. By 1995 the rate had climbed back up to 10.9 percent, and in 1996 it was estimated to be 9.0 percent.

The national goal remains as clear today as it was in 1991 when the first *Policy Report of the Physician Consortium* was issued: reduce the number of people reporting current illicit drug use and the number of drug-related emergency room incidents by 15 percent in two years, by 55 percent in ten years. The 1995 report, *The Health of the Nation, 1995 Report on Progress,* provides some evidence of positive movement:

- From a baseline of 29% of the population who smoke, the 1995 baseline was changed to 25%. New youth smokers declined from 30% to 27%. Year 2000 targets remain 15% for both groups.
- Reduction of alcohol-related vehicle deaths is considered to be highly successful. From a 1987 baseline of 9.8 deaths/100,000 the Year 2000 target of 8.5 deaths/100,000 had been achieved by 1993 with a rate of 6.8 deaths/100,000.
- Although the average age of first use of cigarettes, alcohol, or marijuana had not changed in 1993, alcohol and marijuana use overall had declined among 12-17 year old youth according to the National Household Survey. Beginning in 1992, unfortunately, usage began to increase again.
- The 1994 Monitoring the Future survey showed that alcohol use among high school seniors declined to the lowest level recorded by this survey. The same survey showed an increase in marijuana use. These use patterns may derive from apparent declines in high school seniors' perception of social disapproval about heavy use of alcohol, occasional use of marijuana and trying cocaine.
- The 1995 progress report suggests increasing the number of primary care providers who are willing and trained to screen for alcohol and other drug use problems. The 1992 Primary Care Providers Survey established a baseline for this objective; 63% of internists said that they routinely inquire about alcohol use and 34% routinely inquire about drug use.
- Drug abuse-related emergency room visits have risen and are moving away from the year 2000 target, as is the number of drug-related deaths, which increased in 1992 to 4.3/100,000.[3]

3. Information reported in this section was drawn from the Healthy People 2000 Midcourse Review and 1995 Revisions published on-line by the Office of Disease Prevention and Health Promotion.

VII. PRE-TRIAL SERVICES

The decision of whether to release or detain a defendant pending case disposition is one of the most important decisions in a criminal case. It involves balancing an individual's liberty rights with the government's interests in meting out justice and protecting the public. The unintended consequences of uninformed decisions are far reaching. The detention of a person unable to post bail is an example. Not only does this result in a person's loss of liberty during the pretrial stage, but it increases the likelihood of a person being convicted, and, once convicted, the likelihood of receiving a prison sentence. Finally, pre-trial detention contributes to crowded conditions in local jails.

On the other hand, the unintentional release of a person who is a high risk of flight or danger to the community can pose extra burdens on the criminal justice system (i.e., the need to issue and serve warrants to persons who abscond) and endanger the public safety. The role of pre-trial services programs is to assist judicial officers in making informed release or detention decisions and thereby avoid or minimize those unintended consequences.

A generic pre-trial services program performs the following basic functions:

- provides complete, accurate, non-adversarial information to judicial officers to assist them in making informed release/detention decisions;
- identifies criminal defendants for whom pretrial release, with or without supervision, is appropriate; and
- monitors criminal defendants who are conditionally released.

The specific tasks performed as part of the first function entail interviewing and verifying information about criminal defendants. The information includes personal identifiers such as name, aliases, date of birth, social security number and other numbers assigned by a criminal justice agency, residence and employment history, address and telephone number, criminal history information, and names and addresses of persons who could verify the information obtained in the interview. The verification may involve contacting not only the provided references but also criminal justice personnel and conducting an independent records check.

The second function involves making recommendations to the court concerning the release/detention decision, and, if the defendant is released, the appropriate release conditions. The recommendation is a research-derived assessment to determine a defendant's eligibility for release and under what conditions.

The third and final function consists of checking that the released defendants comply with their release conditions and reporting to the courts on the conduct of released persons.

In addition to these critical functions, pre-trial services programs may perform a variety of other functions, including notifying released defendants of upcoming court dates, testing for drug use, supervising the defendant, reviewing cases of defendants detained after initial appearance (i.e., hearing when bail is set by a judicial officer) and assisting defendants in securing social services.

A pre-trial services program is considered a neutral (i.e., non-adversarial) entity that can operate under a variety of organizations, at the state or local — usually county — level. A pre-trial program can be in the organizational structure of a sheriff's office, the courts, the jail administrator's office, the probation office, or be conducted by an independent organization contracted by the county. For a pre-trial services program not only to be, but also to have the appearance of being, a neutral entity it is uncommon for such a program to be in the prosecutor's or public defender's office. There are programs, however, that are operated by a local bar association.

Funding for a pre-trial program can be from a local or state source or a combination of both. Pretrial programs come in all sizes, ranging from a one-person operation, typically in a rural jurisdiction, to a several hundred-employee office in a large, urban jurisdiction.

VIII. BACKGROUND ON DRUG COURTS

For several decades drug use has shaped the criminal justice system. Drug and drug-related offenses are the most common crime in nearly every community. Drug offenders move through the criminal justice system in a predictable pattern: arrest, prosecution, conviction, incarceration and release. In a few days, weeks, or months the same person may be picked up on a new charge, and the process begins again.[4]

The segment of society using drugs between 1950 and 1970 expanded with the crack cocaine epidemic of the mid-1980's, and the number of drug arrests skyrocketed. Early efforts to stem the tide only complicated the situation. Initial legislation redefined criminal codes and escalated penalties for drug possession and sales. These actions did little to curtail the illicit use of drugs and alcohol. As law enforcers redoubled their efforts, America's prisons were filled, compromising Federal and State correction systems' abilities to house violent and career felons. Some States scrambled to "build out" of the problem, spending hundreds of millions of dollars on new prisons, only to find that they could not afford to operate or maintain them.

Other jurisdictions, encouraged and supported by the Federal Government, developed Expedited Drug Case Management systems and were the first to adopt the term "drug court." These early efforts sped up drug case processing by reducing the time between arrest and conviction. Existing resources were used more efficiently, and serious drug trafficking cases were processed more rapidly. However, these efforts did little to address the problems of habitual drug use and simply sped up the revolving door from court to jails and prisons and back again.

As offenders flooded the criminal justice system, many were not identified as having problems with alcohol and other drugs or were released to the community without referral to treatment. When they were identified, attempts by judges to refer them to treatment often yielded meager gains, either because the few alcohol and other drug (AOD) abuse treatment programs were full and waiting lists were long, or because cooperative working relationships between criminal justice agencies and AOD treatment providers were inadequate or nonexistent. In addition, the majority of drug abusers ordered by judges to participate in treatment did not remain involved in the process long enough to develop behaviors and skills for long-term abstinence.

The traditional adversarial system of justice, designed to resolve legal disputes, is ineffective at addressing AOD abuse. Moreover, many features of the court system actually contribute to AOD abuse instead of curbing it: Traditional defense counsel functions and court procedures often reinforce the offender's denial of an AOD problem. The offender may not be assessed for AOD use until months after arrest, if at all. Moreover, the criminal justice system is often an unwitting enabler of continuing drug use because few immediate consequences for continued AOD use are imposed. When referrals to treatment are made, they can occur months or years after the offense and there is little or no inducement to complete the program.

In response, a few forward-thinking and innovative jurisdictions began to reexamine the relationship between criminal justice processing and AOD treatment services. Several commonsense improvements sprang up spontaneously throughout the Nation. It became increasingly apparent that treatment providers and criminal justice practitioners shared common goals: stopping the illicit use and abuse of all addictive substances and curtailing related criminal activity. Each system possessed unique capabilities and resources that could complement the other and enhance the effectiveness of both if combined in partnership. Thus, the concept of treatment-oriented drug courts was born.

4. The material in this section describing drug courts has been extracted from a Department of Justice web page.

Drug courts were first implemented in the late 1980's, but they did not develop in a vacuum. They are an outgrowth of the continuing development of community-based team-oriented approaches that have their roots in innovative programs developed by pre-trial, probation, and parole agencies, as well as treatment-based partnerships such as TASC (Treatment Alternative to Street Crime) and law enforcement innovations such as community policing programs.

Nor are drug courts the culmination or focal point of this evolution in community-based court programs. "Community courts," encouraged by the success of drug courts, have emerged over the past several years to include domestic violence courts, DUI (driving under the influence) courts, juvenile and family drug courts, neighborhood courts and even "deadbeat dad" courts. These courts are designed to reflect community concerns and priorities, access community resources, include community organizations in policymaking decisions and seek general community participation and support.

Drug courts and other new and innovative community-based court programs making up the community court field are, in turn, part of the "community justice" field. Along with community policing, community prosecution and community corrections, these programs are evolving fast, gaining momentum, and spreading across the country. As the community justice field evolves into the 21st century, so too will drug courts.

What is a Drug Court?

The mission of drug courts is to stop the abuse of alcohol and other drugs and related criminal activity. Drug courts offer a compelling choice for individuals whose criminal justice involvement stems from AOD use: participation in treatment. In exchange for successful completion of the treatment program, the court may dismiss the original charge, reduce or set aside a sentence, offer some lesser penalty or offer a combination of these.

Drug courts transform the roles of both criminal justice practitioners and AOD treatment providers. The judge is the central figure in a team effort that focuses on sobriety and accountability as the primary goals. Because the judge takes on the role of trying to keep participants engaged in treatment, providers can effectively focus on developing a therapeutic relationship with the participant. In turn, treatment providers keep the court informed of each participant's progress, so that rewards and sanctions can be provided.

Drug courts create an environment with clear and certain rules. The rules are definite, easy to understand, and most important — compliance is within the individual's control. The rules are based on the participant's performance and are measurable. For example, the participant either appears in court or does not, attends treatment sessions or does not. The drug tests reveal drug use or abstinence. The participant's performance is immediately and directly communicated to the judge, who rewards progress or penalizes noncompliance. A drug court establishes an environment that the participant can understand—a system in which clear choices are presented and individuals are encouraged to take control of their own recovery.

The Planning Process

Drug courts require a coordinated, systemic approach to the drug offender. Comprehensive and inclusive planning is critical. Planning begins with a vision of what will be achieved when the drug court succeeds. A mission statement evolves from this vision, giving rise to goals and objectives that create form and function. Clearly defined goals and objectives should be measurable and provide accountability for State and local funding agencies and policymakers who ultimately will ensure the continuation of the court.

Planning must be detailed and thorough and must include as many perspectives as possible. A myriad of issues must be addressed, including offender identification and eligibility criteria; treatment methods, expectations, and support service availability; organizational coordination; formal policies and procedures; contractual and budgetary agreements; ongoing supervision; and process and outcome evaluation.

The judge, court administrator, clerk, prosecutor, defender and other staff are particularly important to the planning process. The initial planning group should also include representatives from State and local treatment provider agencies, law enforcement, pretrial services, jails, probation services and other community-based organizations. This core group develops a work plan addressing the operational, coordination, resource, information management and evaluation needs of the program. The work plan should be specific, describing roles and responsibilities of each program component. For example, eligibility criteria, screening and assessment procedures must be established. Both court and treatment case management procedures and information systems must be developed. Graduated responses to both participant compliance and noncompliance must be defined. Treatment requirements and expectations need to be understood and agreed to by the planning group.

Drug court programs should have the capacity to demonstrate tangible outcomes and cost-effectiveness. It is unlikely that drug courts will thrive without demonstrating reductions in AOD use, decreases in criminal behavior and improvements in the employability and educational levels of participants.

As the planning process continues, additional challenges will arise. Once the drug court begins, what isn't working will quickly become apparent and must be adjusted or modified. Key personnel will change over time. Experience will bring growth and expansion. Mechanisms must already be in place to address these challenges.

Although the plan may never be perfect, the time allotted for planning should be sufficient to consider all of the critical issues, but short enough to implement while enthusiasm for the new endeavor is high.

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